STATE OF CALIFORNIA Steve Poizner, Insurance Commissioner

DEPARTMENT OF INSURANCE
Consumer Services and Market Conduct Branch
300 South Spring Street, South Tower
Los Angeles, CA 90013
(800) 927-HELP
(213) 897-8921
www.insurance.ca.gov

CCB-002 B
Revised: (12/21/06)

AUTO BODY REPAIR SHOP REPORT FORM

Name of Automobile Body Repair Shop:	**Business Phone:**
Address:	**Name of Reporting Person:**
City : **State:** **ZIP:**	**Position:**

1. Complete name of insurance company involved :

2. Are you reporting a denial in an insurer's Direct Repair Program? Yes ____ No ____ If Yes, Skip to Question 8.

3. Type of Insurance: AUTO

4. Name and Address of the policyholder/claimant/customer:

5. Policy identification number:

6. Claim number:

7. Date loss occurred or began:

8. Name of Adjuster or Insurance Company Representative:

9. Have you reported this to any other governmental agency? Yes ___ No ___
If yes, Please give the
Name of the Agency: _____ *File number, if known:* _____

10. Have you previously written to the California Department of Insurance about this matter?
Yes __ No __ File number (if available) _____**Date submitted**_____

10. Briefly, describe the details of the transaction and provide any documentation to support your allegations.

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_____ _____

Signature **Date**